Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

COMBINED CHIROPRACTIC SERVICES & REHABILITATION INC
P O BOX 700311
SAN ANTONIO TX 78270

Carrier's Austin Representative Box

Box Number 19

Respondent Name

AMERICAN ZURICH INSURANCE CO

MFDR Date Received

October 13, 2011

MFDR Tracking Number

M4-12-0480-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Taken from the Letter of Reconsideration: "In this packet you will find the denial of services EOB and HICF and the proper documentation such as doctors notes as needed for the request for reconsideration. The patient has was approved 10 sessions of CPMP the chronic pain program and it was approves and the PPE was used to determine what kind of categories the patient falls in and how much she can with stand so the PPE was done and the it was used to determine the ability for what the patient can perform and again they approved her for 10 session more. Please review and resubmit for payment there are no grounds for denial and the preauthorization number for the CPMP is #110610214962001 for 10 sessions, the chronic pain management program is to help the patient decrease of pain and medication and to rebuild strength and reduce fear of tasks from the issues of her injury and to help her overcome any issues from her injury, again please review and submit for payment. The criteria were met according to the definition of a PPE (Physical Performance Evaluation)…"

Amount in Dispute: $520.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The claimant allegedly presented to the requestor for a physical performance evaluation. The requestor billed $520 for the evaluation, and submits it is entitled to reimbursement in that amount. The carrier submits that no reimbursement is due because the requestor has not provided sufficient information to explain the service rendered."

Response Submitted by: Flahive Ogden & Latson, P. O. Box 201320, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 14, 2011	CPT code 97750-GO x 8 Units (Physical Performance Evaluation)	$520.00	$389.62

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement of professional medical services provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 1, 2011
   - 16 — CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.
   - 205 — THIS CHARGE WAS DISALLOWED AS ADDITIONAL INFORMATION/DEFINITION IS REQUIRED TO CLAIRFY SERVICE/SUPPLY RENDERED.

   Explanation of benefits dated September 21, 2011
   - 18 — DUPLICATE CLAIM/SERVICE.
   - 224 — DUPLICATE CHARGE.

Issues

1. Is the respondent's denial reason code '16' supported?
2. What is the description of a Physical Performance Evaluation (PPE)?
3. Did the requestor submit documentation support the Physical Performance Evaluation (PPE) billed?
4. Is the requestor entitled to reimbursement?

Findings

1. The respondent initially denied the disputed CPT code 97750-GO with denial reason code, "— Claim/service lacks information which is needed for adjudication." It is shown that upon subsequent submission of the billing that the respondent did not maintain denial reason code '16' on the re-audit dated September 21, 2011. The Division will review the billing according to the applicable rules and fee guidelines.
2. CPT code 97750-GO is described as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes." "The health care provider performs a test of physical performance evaluating function of one or more body areas and evaluates functional capacity. A written report is included. This is in addition to a routine evaluation or re-evaluation. This code can be billed in 15 minute increments."
3. The requestor's documentation was reviewed. The Division finds submitted documentation sufficiently supports the criteria were met according to the documentation requirements of a Physical Performance Evaluation (PPE). Therefore, this dispute will be reimbursed according to 28 Texas Administrative Code, Section §134.203.
4. Per 28 Texas Administrative Code, Section §134.203(c)(1) the calculations for CPT code 97750-GO is as follows:

   CPT Code 97750-GO: $54.54 WC CF/33.9764 Medicare CF x $30.34 participating amount x 8 Units = $389.62

   The total MAR for CPT code 97750-GO x 8 Units billed on July 14, 2011 is $389.62. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $389.62.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to

reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $389.62 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 2, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.